ISDH HOSPITAL SERVICE REPORT
STATE FORM 49476 (R / 7-02)
IC 16-21-6

I. Hospital Information

Hospital Name		Provider #	

City		County		Year	

Person Completing Report		E-Mail	

LICENSURE, ACCREDITATION, OR DESIGNATED UNITS (type "Y" to all that apply)											
State Licensure	Acute License				LTC Certification						
Private Accreditation	JCAHO				HFAP						
CMS Specialized Hosp		CAH			LTC			Rehab			
DRG Exempt	Psych			Rehab				Swing Bed			
Number of Total Hospital Full Time Equivalents											

II. Hospital Service Utilization

HOSPITAL SERVICE DESCRIPTION	NUMBER OF SET-UP BEDS	NUMBER OF DISCHARGES	NUMBER OF PATIENT DAYS	ANNUAL TOTAL CHARGES
Burn Care				$
Cardiac Intensive				$
ICU Medical/Surgical				$
ICU Neonatal				$
ICU Pediatric				$
Medical/Surgical				$
Neonatal Intermediate				$
Obstetrics				$
Pediatric				$
Psychiatric				$
Rehabilitation				$
Substance Abuse				$
Swing Bed Program	NA			$
Extended Care				$
Observation Beds				$
All Other Services				NA
Total Acute				NA

Normal Newborn				$

ISDH **Hospital Service Report** Continued

III. Nursing Facility Utilization

	NUMBER OF LICENSED BEDS	NUMBER OF DISCHARGES	NUMBER OF PATIENT DAYS
Nursing Facility			

IV. Number of Outpatient Encounters By Diagnostic Group

Please identify the number of outpatient encounters for your hospital by ICD-9-CM Diagnostic Categories.

DIAGNOSTIC CATEGORIES	NUMBER OF ENCOUNTERS	DIAGNOSTIC CATEGORIES	NUMBER OF ENCOUNTERS
Infectious Disease		HIV	
Neoplasms		Endocrine	
Diseases of Blood		Mental Disorders	
Nervous		Circulatory	
Respiratory		Digestive Diseases	
Genitourinary		Pregnancy	
Skin		Musculoskeletal	
Congenital		Perinatal	
All Injuries			
Other / Unknown		Total Encounters	

TOTAL ED VISITS	ED INJURY VISITS	ED INJURY ADMISSIONS

COMMENTS
